

# The Opportunity Project Permission Sheet

**Child's Last Name:** \_\_\_\_\_ **First:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_

Parent/Guardian: Please circle "Yes" or "No" below. We will also need your signature at the bottom of this sheet. Thank you!!!

## Health Services

1. I give permission for my child to receive vision, hearing and psychological screening, which will be provided by qualified professionals such as staff, students nurses (under supervision), psychologist, dentists or volunteers. Yes No
2. I understand that if The Opportunity Project provides any of the services listed above in item#1, I will not be charged for such services. Yes No

## Miscellaneous Consents

1. I understand that my child will occasionally take educational walks/fields trips (Permission will be requested prior). Yes No
2. I understand that my child's education is important and I agree to have my Child at school **On Time**, unless other arrangements have been made. (Breakfast is at 8:00a.m.) If you arrive after 8:00a.m., the teacher will give you food for your child and parents will be asked to sit with their child until he/she is finished eating. Yes No
3. I give permission for my child to be photographed or video-taped for the use of The Opportunity Project and for the media. (newspaper, television and information articles). Yes No

## Confidentiality of Information

1. I understand I have the right to review my child's records with a member of The Opportunity Project staff upon request. Yes No
2. I understand that I will be encouraged to be involved in the education of my child. Yes No
3. I understand that my child will be participating in the Child and Adult Care Food Program (CACFP). Yes No
4. I understand that information regarding my child will be shared with the Unified School District that my family resides in, Rainbows and TOP. Yes No

**Parent/Guardian Signature)** \_\_\_\_\_ **Date:** \_\_\_\_\_